Full Circle Holistic- A Women's Health-Care Practice

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The Arvigo Techniques of Maya Abdominal Therapy™ Confidential Intake

Date of Initial Visit____________________

Name:____

Address____

City __________________________State__________ Zip_________ Home Phone____________________________

Work Phone_____________________Cell________________________email________________________________

Date of Birth_____________________ Age__________Occupation____

Marital/Relationship status______________________Referred by____

Reason For Visit

Primary reason for visit:____

When did your first notice it?_______________________________What brought it on?___________________________

Describe any stressors occurring at the time____

What activities provide relief?__________________________what makes it worse?______________________________

Is this condition getting worse?_______________________interfere with work?______sleep?______ recreation?_______

Have you had massage/bodywork before?______________ What type?____

Medical History

Are you currently under the care of another health care provider(s)?_______________Reason (s)___________________

____

Name(s) of Practitioner______________________________Address:____

Phone____________________________email____

Current Medications and /orSupplements/Remedies:____

____

Allergies: specify allergen and reaction:____

Surgical History (year and type) and/or Recent Procedures:____

____

Hospitalizations: ____

Accidents or Traumas____

Falls/Injuries to Sacrum/head/tailbone (describe)____

Please review and check the following:

Headaches Type:	Past Present	Numbness in feet or legs when star	Past Present
Asthma		Sore heels when walking	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Low Back Pain		Muscular Tension: Location:	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Herniated/Bulging Discs	
Painful/Swollen Joints		Artifical/Missing limbs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Cancer (past or current) Type	

Other:

Family History

	Still Living?	Cause and Age of Death	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Gastrointestinal Health History

Describe your typical:

Breakfast:____

Lunch:____

Dinner:____

Snacks:___________________________Water Intake(glasses/day)_________________Caffeine_________________

What is the worst item in your diet______________What foods are your weakness___________________________

Are you subject to binge eating?__________________________What foods___________________________________

Do you experience bloating/gas/burps after eating?_____________What foods trigger this?__________________

Food Allergies?_________Describe____

How often are your bowel movements?____________________________Do your stools: sink______float_______

Constipation?__________Blood in stool ?_________Mucus in stool?____________Pain when stooling?_________

Diarrhea?____________________________Other?____

Lifestyle, Emotional & Spiritual

What is your opinion of yourself?____

Describe the most positive emotion you experience____

When and Where do you experience this emotion?____

Describe the most negative emotion you experience____

When and Where do you experience this emotion?____

Describe your Spiritual and/or Religious practice:____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself in each of these qualities:

Faith______Hope____Charity____Generosity________ Sense of Humor_______Fear_____Grief_____Sense of Fun_____

What hobbies/ activities provide you with pleasure and accomplishment ______________________________________

Describe your exercise routine (type, frequency)____ _

What changes would you like to achieve in 6 months:____

One Year**:**____

Do you use Tobacco?______ Quantity_____/ppd Alcohol?______Quantitiy______ounces/ day

Marijuana?_______Quantity______Other:__________________ Have you been under treatment for substance use?__________

Female Reproductive Health History

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method

Fertility Awareness Other:_____________Length of time using method________Last Pap smear____Results _____

Are now or in the past experiencing Fertility Challenges? Yes___No___Describe your treatment :__________________

(IUI, IVF,etc)____

Menstrual History Review and check as indicated:

Age of Menses:___________________________What was this like for you?___________________________________

Last Menstrual Period:________________________Length of Menses____

Are you trying to Conceive? Yes_____No_______ Are you Pregnant? Yes____No____Unsure____

Painful Periods	Past Present	Irregular cycles Early Late	Past Present
Heaviness in Pelvis prior to menses		Dark Thick Blood at: Beginning End Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Bloating	
Water Retention		Ovulation: Painful Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	
Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Vaginal Dryness	
Episodes of Amenorrhea How long?			

Rate your interest in Sex: High_________Moderate__________Low______________None___________________

Do you have or ever had difficulty experiencing orgasms____

Have you experienced trauma? Yes___No____Describe____

Did you undergo counseling for this?____

What was this like for you?____

Pregnancy History

Number of Pregnancies:_____Dates________Miscarriage(s)_______Dates_______Termination(s)______Dates:________________

Number of Births:_________ Dates:____

Complications for any of the above, describe:____

Premature Births?______ Spotting During Pregnancy? _____ Weak Newborns? ______ Incompetent Cervix? _______

Describe your experience with:

Pregnancy:____

Labor:____

Birthing: ____

Post Partum:____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis PMS Menopause

Cancer (type)____________ Menstrual Problems _____________ Other_______________________________

Medications your mother took when she was pregnant with you (if any)__________________________________

Your Birth Trauma (if known) ____

Menopause

Age symptoms began:___________Are they getting worse_________better_______________same_______

Are you on/ or ever been on hormone replacement therapy?_____if so, how long_________________________

Name and dose____

Reason for stopping____

Age of Mother at menopause:_____Concerns/Experience____

Check the following symptoms that apply to you:

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Additional Information you feel important your practitioner should know that is not mentioned here: